FORM 160

The Commonwealth of Massachusetts
Department of Industrial Accidents
600 Washington Street – 7th Floor, Boston, Massachusetts 02111
Info. Line 800-323-3249 ext. 470 in Mass. Outside Mass. - 617-727-4900 ext. 470
http://www.mass.gov/dia

EMPLOYEE BIOGRAPHICAL DATA

PREPARE THIS FORM PRIOR TO A HEARING. THIS FORM IS TO BE GIVEN TO OPPOSING COUNSEL AND MAY BE OFFERED AS EVIDENCE IF SO TESTIFIED.

Employee

Please Print or Type

1. Employee's Name (Last, First, MI):	2. Social Security Number*:	3. Home Telephone No.:	4. Number of Dependents:
5. Home Address (No., Street, City, State & Zip Code):		6. Date of Birth:	
7. Place of Birth:		8. Date U.S. Domicile Established:	
9. Marital Status:	10. Spouses Name:	11. Spouses Occupation:	

12. Names and Ages of Children (attach additional sheet if needed):

1. Age _____ 2. Age_____
3. Age_____ 4. Age_____
5. Age_____ 6. Age_____

Education

13. Name & Address of Last School Attended:	14. Highest Grade Completed and/or Date of Graduation:
15. List any Special Skills or Training Received:	

Military Service

16. Branch of Service and Rank:	17. Dates of Service (mm/dd/yyyy):
18. Military Occupation or Specialty:	

Work History (begin with most recent employment)

19.

A. Employer: _____ From _____ To _____
Job Description: _____
_____
_____

B. Employer: _____ From _____ To _____
Job Description: _____
_____
_____

*Disclosure of Social Security No. is optional. It will aid in processing forms. (OVER)

Work History - Continued

19.

C. Employer: _____ From - _____ To _____

Job Description: _____

_____

_____

D. Employer: _____ From - _____ To _____

Job Description: _____

_____

_____

E. Employer: _____ From - _____ To _____

Job Description: _____

_____

_____

Medical Data (related to industrial injury)

20. Date of First Medical Treatment (mm/dd/yyyy):	21. Place of First Medical Treatment:

22. Name(s) of Treating Physicians and Dates of Treatments (in Chronological Order):

a.	Date _____	b.	Date _____
c.	Date _____	d.	Date _____
e.	Date _____	f.	Date _____

23. Date(s) and Location(s) of **OUTPATIENT** Hospital Treatment:

_____

_____

_____

24. Date(s) and Location(s) of **INPATIENT** Hospital Treatment:

_____

_____

_____

25. List any Hospital Records and/or Physician reports to be Offered in Evidence by Agreement of Counsel (Please Attach):

_____

_____

_____

_____

_____

_____